ATTENDING PHYSICIAN'S STATEMENT FOR DEATH CLAIM



Please print in BLOCK Letters

(to be completed by the deceased's last attending physician without expenses to insurance company)

Name of Policyl	nolder:		Policy No.:				
Name of Decea	sed:		Member No.:				
Sex: Age: _	Date of Birth (day/	month/year):	Passpo	Passport/ I.D.No.:			
Residence at the	time of death:						
Occupation prio	r to death:						
				re details of the last attending physician?			
b. Date on wh	nich you first saw the dec	reased?					
c. Who referr	ed the deceased to you?	Please indicate his	s/her full name and	d address			
d. How long	have you acquainted with	the deceased?					
e. Please give	particulars of any illness	es or investigation	ns for which he/s	he has consulted you:			
Date Attended (day/month/year)	Complaints & Abnormal Physical Findings	Duration of Illness	Diagnosis	Describe Treatment (including name of drugs prescribed) or Operation			

2. a. Date of death: _						
c. Cause of death:						
3. To the best of your	knowledge, please give i	names and address of all other	er physicians wh	no attended	the deceased	
during the past three y	rears.					
Date	Date Details of N		Nat	ame and address		
(day/month/year)	Disease/ Disorder			of the physicians		
(33), 333333, 333				or the physicians		
4. Was there any medi	ical condition in any way	contributed or predisposed	to the cause of	death? If	"yes", please	
provide details.						
5. a. Did the deceased	Yes 🗖	No 🗖				
b. Did the deceased	Yes 🗖	No 🗖				
c. Did the deceased	Yes 🗖	No 🗖				
d. Was the death re	Yes 🗖	No 🗖				
For Females Only:						
e. Was the death rel	Yes 🗖	No 🗖				
For any "yes" answ	ver, please state the quest	ion number and give details				
6 Was there any post-	-mortem examination do	ne in the deceased's body?		Yes 🗖	No 🗖	
If "yes", please give	100	± 10				
		claim assessor to release the	information	Yes 🗖	No 🗖	
		ed's family and/or claimant(s)		100	± 10	
1 , ,	1	or claimant(s), to explain our				
-	•	, ,				
•		mined and treated the pati	ient for the ab	ove illnes	s and that	
the facts as given ab	ove present my opinion	n of his/her conditions.				
Name of Attending Pl	Signature (v	_ Signature (with stamp):				
Qualification:		Date (day/s	Date (day/month/year):			
Tel:						
Fax:						
Email:						